

INCONTINENCE CARE

INTRODUCTION

Urinary incontinence is the inability to control urination; it can range in severity from slight leakage to total loss of bladder control

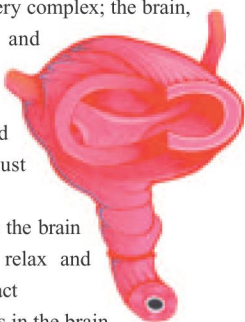
This chart is designed to help you understand the causes of incontinence and give helpful hints on its management; **this information is not a substitute for professional medical care**; always consult your physician if problems arise

It is estimated there are over 13 million incontinent adults in the U.S. today; women are twice as likely to have this condition as men; children may also have bladder control problems; urinary incontinence is treatable and usually does not require surgery; some causes of incontinence include muscle weakness, an enlarged prostate blocking the urethra, and diseases or injuries involving nerves and muscles; pregnancy, bladder infections and certain medications may temporarily cause incontinence

NORMAL CONTROL OF URINE

- Urine control is very complex; the brain, spinal cord and muscles of the bladder, urethral sphincter and pelvic floor must work together

- Urine is stored when the brain makes the bladder relax and pelvic muscles contract
- When control centers in the brain quiet, the pelvic muscles relax, and the bladder can squeeze and empty



BLADDER

Medications that can affect bowel or bladder control:

Diuretics	Anti-hypertensives
Sedatives	Antihistamines
Narcotics	Antidepressants

TYPES OF INCONTINENCE

Stress Incontinence:

- Occurs when the pressure closing the bladder is greater than the pressure in the urethra
- Results in loss of urine while coughing, laughing or changing position
 - Most prevalent in women, especially after childbirth and hysterectomy
- Occurs when the muscles and tissues closing or supporting the urethra are weak or damaged, such as with childbirth, weight gain or some types of surgery
- May worsen with altered levels of estrogen during the menstrual cycle, or after surgical or natural menopause
- Surgery is designed to restore the normal position of the bladder and/or the bladder neck and urethra

Urge Incontinence:

- An overwhelming urge to urinate, followed by the release of a sometimes large amount of urine
- Caused by bladder wall spasms; also described as *unstable, spastic or overactive*
- Can be set off by the sound of running water, walking past a favorite bathroom, returning home, or sudden bladder filling due to alcohol or other diuretics
- Common after menopause and in older persons when the bladder muscle is more irritable
- Also common when MS, diabetes, stroke or Parkinson's interrupts control messages from the brain's higher centers
- Irritation sometimes increased by concentrated urine from inadequate fluid intake, or by caffeine, citrus juice, artificial sweeteners, or spicy foods
- Usually not related to excess urine in the bladder but rather to an irritated bladder muscle from infection, bladder calculi (stones), polyps or cancer

Overflow Incontinence:

- Leakage of typically small amounts of urine when the pressure in an overfull bladder overcomes the pressure in or around the urethra
- May cause urine to flow back up into the kidneys, damaging or destroying them
- Usually due to either a bladder that contracts weakly or a blockage of the urethra
- Common in men with an enlarged **prostate**, especially when taking cold medications
- Nerve damage** due to **diabetes, spinal injury, MS** or a **birth defect** may prevent bladder wall muscle from contracting or prevent muscles that close the urethra from relaxing
- Treatments include medication review, surgery to remove obstruction, clean intermittent catheterization, and as a last resort, indwelling catheterization
- Urethral blockage may cause bladder spasms/instability over time that persists after prostate surgery

Functional Incontinence:

- Occurs in people with borderline bladder control who are **unable** to reach the toilet in time because of **physical problems** like arthritis or muscles affected by a stroke
- Also caused by **environmental barriers**, such as stairs, distance or crowds preventing timely access to bathroom
- May occur in those with **dementia** or **severe depression** who don't remember how to get to the bathroom or even care about it
- Offering **assistance** to get to the bathroom every 1—2 hours and a drink of water following use of the toilet may correct this
- Having a **commode** nearby or keeping the route to the bathroom free of obstacles and well lit may also help

Fecal Incontinence (loss of normal bowel control):

- There are over 1 million people in the US suffering from fecal incontinence
- Commonly caused by chronic constipation from inadequate fiber and fluids
- May also be caused by a weak anal sphincter
- Ignoring the first urge to have a BM causes the stool to dry out, increasing constipation
- When unable to expel hard rectal contents, liquid stool higher in the intestine may move past the obstruction, giving the appearance of diarrhea
- A full rectum also may press against the bladder or urethra, and cause urinary problems

EVALUATION OF INCONTINENCE

Evaluation of Incontinence:

- Focused history and physical examination
- Analysis of a urine sample
- A toileting diary covering several days, recording toilet use and accidents
- Stress test – observation of leakage with activity
- Measurement of urine in bladder after urinating

Specialized tests not part of basic evaluation:

- Urodynamics:** Determination of functional status of urinary bladder and urethra
- Cystoscopy:** A narrow telescope-like tube is used to help in identifying lesions, pouches, holes and blockages
- Imaging:** Examines the bladder, ureters and kidneys for lesions and blockages

Summary of information collected to diagnose possible causes of incontinence:

- | | |
|----------------------------|--|
| • Focused history | • A diary, covering several days, recording toilet use and accidents |
| • Physical examination | • Estimate of urine left in bladder after emptying it |
| • Analysis of urine sample | |

CATHETERIZATION

Indwelling catheterization

Indicated only when urine output must be closely monitored, incontinence hampers healing of a stage 3 or 4 pressure ulcer, in the terminally ill to avoid undue pain or trauma, or as the last resort to avoid institutionalization

- Insertion is a sterile procedure to prevent UTI
- Use the smallest catheter that drains well (14 or 16 Fr.)
- Avoid balloons > 10 ml, unless for hemostasis
- Base catheter changes on patient need, not a predetermined interval
- Urine may leak around catheter because of bladder spasms, too large a catheter or balloon, catheter blockage or infection

Intermittent self-catheterization

- Far safer over time than an indwelling catheter
- Clean technique and washing catheter with soap and water is recommended
- Catheter guides, grasp aids and mirrors may assist females but should be ultra-portable to avoid postponing catheterization

SKIN CARE

- Urine and especially feces can seriously damage skin if allowed to remain
- Use absorptive products with polymer gel and change when wet
- Wash skin with incontinence wipe or cleanser but avoid excess friction; avoid soap as it removes natural protective lubricants
- Barriers such as the petroleum-based products and zinc oxide protect against breakdown
- Skin breakdown or pressure ulcers (bedsores or decubiti) are increased with mobility limitations
- Collection devices help when treatment fails; there are many types (disposable & reusable): liners, drip collectors, condoms, pads, guards, undergarments, briefs and bed pads; device should be comfortable and discreet, and keep skin, clothes and furniture dry; overpadding damages skin and reduces leakage awareness

(Also consult BarCharts® *Wound Care Guide*)

TREATMENT

Behavioral Techniques: These decrease the frequency and amount of incontinence in most persons when used by experienced health care providers, have no reported side effects and do not limit future treatment options; clinical practice guidelines typically suggest trying behavioral methods first; listed in order of participation required:

- **Scheduled toileting:** Help offered at fixed or regular intervals
- **Habit training:** Toileting scheduled to match usual voiding habits
- **Prompted voiding:** Person is asked if they are wet or dry, assisted to the bathroom, and praised for appropriate toileting
- **Pelvic muscle rehabilitation:** Exercises making the pelvic floor bulkier, giving better closure and support to the bladder
- **Urge suppression:** Using pelvic muscle contractions, controlled breathing and/or distraction to quiet an irritable bladder
- **Bladder training:** Drinking adequate fluid and gradually prolonging voiding intervals

Other Interventions

- **Medicine:** Over-the-counter and prescription drugs may be beneficial but some have side effects, such as a dry mouth
- **Pessary:** A rubber, silicon or plastic device inserted in the vagina to give additional support
- **Electrical stimulation:** Uses a vaginal or rectal probe to make pelvic muscles tighten
- **Implanted nerve stimulator:** Implanted near the sacral area of the spine to stimulate nerves controlling bladder function
- **Artificial sphincter:** Inflatable ring surgically implanted around the urethra or rectum; patient squeezes bulb to temporarily transfer water from the ring to an internal reservoir, allowing emptying of the bladder or bowels
- **Other surgery:** Goal is to restore the normal position of the bladder and/or urethra, or to relieve urethral or prostatic obstruction

PELVIC FLOOR EXERCISES

These exercises strengthen muscles that support the pelvic contents and close off the urethra and anus. Guidance of a health care professional is helpful; exercises usually improve control, but only if:

- They are done regularly and correctly
- Pelvic muscles are completely relaxed before beginning exercises
- Abdominal and gluteal muscles are kept relaxed throughout the entire exercise
- Breathing is regular, without holding at any time
- Exercises are not done to point of exhaustion

How to do Pelvic Floor Muscle Exercises:

- Locate correct muscle by pretending you are trying to avoid passing gas; **never** practice by repeatedly interrupting the urine stream
- A **lifting** and tightening sensation can be felt when done correctly; men will see the base of their penis pull in; women can feel pressure when two fingers are inserted into the vagina
- Keep muscles **tense** as long as comfortable, between 2-5 seconds at first

QuickStudy

- Relax muscles for the same duration
- Repeat a total of 10 times, if possible
- Do exercises each time the bladder has been emptied, or at other times, to a total of 50 squeezes daily
- Over a period of weeks, try to **build up** to 10-second holds, with 10-second rests in between

Aids to learning PFM Exercises:

Dr. Kegel pioneered pelvic floor muscle exercises in the 1950s as a way to regain bladder control without surgery; he gave his patients a simple pressure sensor to use for biofeedback because he had observed that 40% of them could not learn to exercise properly with just verbal instruction

- **EMG, surface or internal:** Displays on a computer monitor the signals nerves send to the support muscles and external sphincters, making it easier to learn to control and strengthen them; home devices are also available
- **Vaginal pressure sensor:** Worn in vagina while exercising, with a measuring device attached
- **Vaginal weights:** Tampon-shaped devices graduated in weight, worn in the vagina while walking

GLOSSARY

anus: Outlet of rectum, containing sphincter muscles to close it off; lies in the fold between the buttocks

bed & chair pad: Reusable or disposable; that protects upholstered furniture or mattress

commode: A portable toilet

biofeedback: Sound or visual display of any normally non-visible bodily function, so as to learn to modify it; often used to gain control of muscles which support and close off urethra and anus

bladder: A balloon-like muscular organ that stores and empties urine

BPH (Benign Prostatic Hypertrophy): Non-cancerous enlargement of prostate, common in older men; usually controlled by medication; if the passage of urine becomes completely blocked, this is an emergency, and medical help should be sought immediately

briefs (reusable): Absorbent adult diaper with elastic (pullup), snaps, or plastic and tape at the hip

catheter: A soft tube that is inserted through the urethra to drain the bladder

catheter guide: Plastic device that helps a female find her urethra during catheterization

condom or external catheter: Worn on the penis (similar to a condom) and connected to a leg bag or bedside drainage bag

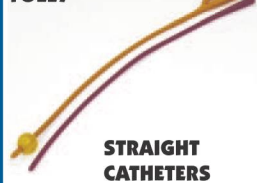
drip collector: Absorbent pocket that holds the penis and adheres to the undergarment, to collect small amounts of urine

enuresis alarm: A sensor used in the crotch of pajamas or in a bed pad, to set off an alarm when wet

fecal impaction: Hardened stool or feces in the rectum which prevent normal bowel movements

foley catheter: Catheter with a built-in "balloon" inflated after insertion, to hold the catheter in place

FOLEY



STRAIGHT CATHETERS

It is connected to a drainage bag and used during surgery to monitor outflow during critical conditions, or when no other method to control urine is feasible; causes dependence; may damage bladder and urethra, and allows bacterial invasion; bladder infections are difficult to control while it is being used

guard: Incontinence protection that is slightly larger than a pad, with plastic or foam on the outside; holds more than a pad

Kegels: Pelvic floor muscle exercises done using biofeedback, pioneered by Arnold Kegel, MD

kidneys: Two bean-shaped organs that filter waste from the blood and produce urine

leg bag: A plastic pouch connected to a catheter, supported by a pocket in a garment or by straps fastening it to the leg

lubricating jelly:

Liquid substance used to lubricate a catheter to make insertion easier

nocturia: Excessive (>2) urination during night

nocturnal enuresis: Urine leakage during sleep

pads: Shaped like a sanitary napkin, but especially designed for urine collection, so less likely to leak

penile clamp: Semi-rigid clamp that surrounds the penis to control accidental urine loss

pelvic floor muscles: Group of muscles extending from the pubic bone to the tail bone, providing support for the pelvic organs, and opening and closing the urethra and anus

prolapse: Descent of uterus, bladder or other organs toward or past openings in pelvic floor

prostate: A gland in the male pelvis that surrounds the urethra just below the bladder

protective clothing: Apparel with plastic layers or panels to protect against wetting

raised toilet seat: Fits over or attaches to toilet, raising the seat to make it easier to get off toilet

retracted penis pouch: Pouch attached with adhesive barrier at base of penis, to divert urine from an inverted or small penis to a drainage bag

sphincter: The muscle around the urethra or anus, controlling the emptying of the bladder or rectum

undergarment: Similar to a loincloth, with straps attached by buttons or Velcro™; panty liners and pull-up types similar to regular underpants are also available

ureters: Two thin tubes that carry urine from the kidney to the bladder

urethra: Tube from bladder base to the outside, about 8 inches long in men, 1-1½ inches in women

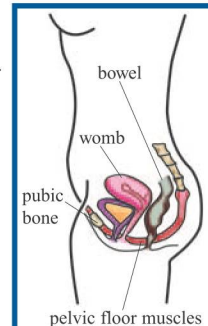
urologist: A doctor who specializes in conditions of the urinary tract in both men and women

UTI (Urinary Tract Infection): Symptoms include burning, frequent and painful urination; in the elderly, behavioral changes may be the only sign

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DRAIN BAG



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DISCLAIMER:

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